



H. I. Bussa Jr. D.D.S. M.S. Inc.

Diplomate of the American Board of Orthodontics

Patient Information

Date _____

Patient's Name _____
Last First Nickname

Address _____
Street City State Zip Code

Home Phone _____ DOB ____/____/____ SS# _____

If patient is a minor, give parents' or guardians' names _____

School _____ Grade _____ Age _____ Sex _____

Brothers (Ages) _____ Sisters (Ages) _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Bill to: _____
Last First M.I. Marital Status

Address _____
Street City State Zip Code

How long at this address? _____ Work Phone _____ Mobile Phone _____

Email Address _____

Previous address (if less than 3 yrs.) _____
Street City State Zip Code

SS# _____ - _____ - _____ DOB ____/____/____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ DOB ____/____/____
Last First MI

Spouse's Employer _____ Occupation _____ SS# _____ - _____ - _____

Work Phone _____ Mobile Phone _____

Email Address _____

Insurance Information

Insured's Name _____ SS# _____ - _____ - _____ DOB ____/____/____

Insurance Company _____ Group # _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Do you have dual coverage? Yes No If yes: _____

Insured's Name _____ SS# _____ - _____ - _____ DOB ____/____/____

Insurance Company _____ Group # _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete address _____

Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Name: _____

Date: _____

Medical History Form

Thank you for taking the time to provide us with this essential information. It will be used each time to select the safest and most effective means of providing you with dental care. Of course, all information on this form is completely confidential.

1. Are you in good health? Yes ___ No ___
2. Has there been any change in your general health within the past year? Yes ___ No ___
If yes, what? _____
3. Are you now under the care of a physician? Yes ___ No ___
If so, what is the condition being treated? _____
4. The name of my physician(s) is (are) _____
5. Have you had any serious illness, operation, or been hospitalized in the past 5 yrs? Yes ___ No ___
If so, what was the nature of your illness? _____
6. Are you taking any medicine including non-prescription medicine? Yes ___ No ___
Medicine _____ Taken For _____ / Medicine _____ Taken For _____
Medicine _____ Taken For _____ / Medicine _____ Taken For _____
7. Do you have or have you had any of the following diseases or problems:
 - a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease? Yes ___ No ___
 - b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) Yes ___ No ___
 1. Do you have chest pain upon exertion? Yes ___ No ___
 2. Are you ever short of breath after mild exercise or when lying down? Yes ___ No ___
 3. Do your ankles swell? Yes ___ No ___
 4. Do you have inborn heart defects? Yes ___ No ___
 5. Do you have a cardiac pacemaker? Yes ___ No ___
 - c. Environmental Allergies? (mold, dust, pollen, animals, food, latex?) Yes ___ No ___
Please specify _____
 - d. Sinus trouble Yes ___ No ___
 - e. Asthma or hay fever Yes ___ No ___
 - f. Fainting spells or seizures Yes ___ No ___
 - g. Persistent diarrhea or recent weight loss Yes ___ No ___
 - h. Diabetes, excessive thirst or frequent urination Yes ___ No ___
 - i. Hepatitis, jaundice, or liver disease Yes ___ No ___
 - j. AIDS or HIV infection Yes ___ No ___
 - k. Thyroid problems Yes ___ No ___
 - l. Respiratory problems, emphysema, bronchitis, etc..... Yes ___ No ___
 - m. Arthritis or painful swollen joints Yes ___ No ___
 - n. Stomach ulcer or hyperacidity Yes ___ No ___
 - o. Kidney trouble Yes ___ No ___
 - p. Tuberculosis Yes ___ No ___
 - q. Persistent cough or cough that produces blood. Yes ___ No ___
 - r. Persistent swollen glands in neck Yes ___ No ___
 - s. Low blood pressure Yes ___ No ___
 - t. Sexually transmitted disease Yes ___ No ___
 - u. Epilepsy or other neurological disease Yes ___ No ___
 - v. Problems with mental health, emotional tension, depression or anxiety Yes ___ No ___
 - w. Cancer Yes ___ No ___
 - x. Problems of the immune system Yes ___ No ___
 - y. Frequent headaches Yes ___ No ___
 - z. Often fatigued or exhausted Yes ___ No ___

Signature: _____

Date: _____

Name: _____

Date: _____

Medical History (Continued)

- 8. Have you had abnormal bleeding? Yes ___ No ___
 - a. Have you ever required a blood transfusion? Yes ___ No ___
- 9. Do you have any blood disorder such as anemia? Yes ___ No ___
- 10. Have you ever had any treatment for a tumor or growth? Yes ___ No ___
- 11. Are you allergic or have you had a reaction to the following medicines:
 - a. Local anesthetics Yes ___ No ___
 - b. Penicillin or other antibiotics Yes ___ No ___
 - c. Sulfa drugs Yes ___ No ___
 - d. Barbiturates, sedatives, or sleeping pills Yes ___ No ___
 - e. Aspirin Yes ___ No ___
 - f. Iodine Yes ___ No ___
 - g. Codeine or other narcotics Yes ___ No ___
 - h. Other..... Please Specify _____
- 12. Have you had any serious trouble associated with any previous dental treatment? Yes ___ No ___
If so, please explain _____
- 13. Do you have any disease, condition, or problem not listed above that you think I should know about? Yes ___ No ___
- 14. Are you wearing contact lenses? Yes ___ No ___
 - a. Glaucoma test normal? Yes ___ No ___
- 15. Are you wearing removable dental appliances? Yes ___ No ___
- 16. Do you smoke? (Packs per day _____) Yes ___ No ___
(Women please continue)
- 17. Are you pregnant? Yes ___ No ___
- 18. Do you have any problems associated with your menstrual period? Yes ___ No ___
- 19. Are you nursing? Yes ___ No ___
- 20. Are you taking birth control pills? Yes ___ No ___

Chief Dental Complaint _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for my errors or omissions that I may have made in the completion of this form.

X

Signature (Parent or Guardian if patient is a minor)

(The following to be completed by Dr. Bussa)

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

Date: _____

Signature of Dentist _____

Medical history update: _____

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign, and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performances reviews, certification, accreditation, and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient's Name (please print)

Patient (18 yrs. or older) OR Parent/Guardian Signature

Relationship to Patient

Date